BEFORE THE KANSAS WORKERS COMPENSATION APPEALS BOARD

MONICA W. NJOROGE	)	
Claimant	)	
V.	)	
	)	
INDIVIDUAL SUPPORT SYSTEMS, INC.	)	
Respondent	)	Docket No. 1,060,477
AND	)	
	)	
COMMERCE AND INDUSTRY INSURANCE COMPANY	)	
Insurance Carrier	)	

ORDER

Claimant appealed the September 8, 2014, Award entered by Special Administrative Law Judge (SALJ) Jerry Shelor. The Board heard oral argument on January 6, 2015.

APPEARANCES

Jeff K. Cooper of Topeka, Kansas, appeared for claimant. Matthew S. Crowley of Topeka, Kansas, appeared for respondent and its insurance carrier (respondent).

RECORD AND STIPULATIONS

The record considered by the Board and the parties' stipulations are listed in the Award.

ISSUES

SALJ Shelor determined claimant failed to provide timely written claim and, therefore, denied compensation for her December 15, 2010, accident.

Claimant requests the Board find she made a timely written claim for workers compensation benefits. At oral argument, claimant asserted respondent may not have filed an Employer's Report of Accident as required by K.S.A. 44-557, thus extending claimant's time to file a written claim. If the Board finds claimant provided timely written claim, claimant requests the Board determine all other issues and not remand this matter to the SALJ. Claimant contends she sustained permanent functional impairments to both knees and her head, is permanently and totally disabled and entitled to future medical treatment.

Respondent asserts claimant's claim should be denied for lack of timely written claim. Respondent claims an Employer's Report of Accident was filed in December 2010. If the Award is reversed, respondent requests the claim be remanded to the SALJ for determination of the remaining issues.

The sole issue before the Board is: did claimant provide timely written claim?

FINDINGS OF FACT

After reviewing the entire record and considering the parties' arguments, the Board finds:

The parties stipulated claimant met with a right knee injury by accident on December 15, 2010, arising out of and in the course of her employment with respondent. Respondent denied claimant sustained a left knee or head injury.

When claimant was deposed, she testified that on December 15, 2010, she was taking a client's trash out when she slipped and fell on ice. She indicated she hit the ground with both knees and then fell back and hit the back of her head. She testified her right knee symptoms are worse than her left. She also has constant dizziness and at times the dizziness is severe. Claimant relates the dizziness to her December 15, 2010, fall.

Claimant testified she notified her supervisor about her accident on December 22, 2010. Claimant indicated she was referred by her supervisor to St. Francis Hospital and Medical Center emergency room for treatment. Claimant received medical treatment from Dr. Laurel A. Vogt at St. Francis on December 22 and 29, 2010. On January 4, 2011, claimant resigned from her job. Her letter of resignation does not state a reason for resigning. At her deposition, claimant testified she resigned because of dizziness and headaches. At the regular hearing, claimant testified she resigned because of dizziness, weakness and blackouts.

On January 5, 2011, claimant again saw Dr. Vogt. Claimant confirmed she was told by Dr. Vogt to return in two weeks, but claimant did not do so because she went to Las Vegas, Nevada, to see a relative. Claimant acknowledged she did not attend physical therapy prescribed by Dr. Vogt. Claimant testified she reported all of her symptoms to Dr. Vogt.

Dr. Vogt testified she saw claimant on December 22, 2010. Dr. Vogt acknowledged claimant never reported striking her head in the fall, nor mentioned experiencing vertigo, headaches or dizziness. The doctor saw claimant again on December 29, 2010, and a systems review revealed no headaches, dizziness, weakness, numbness, seizures, syncope or neck pain. Dr. Vogt testified that at a January 5, 2011, appointment, claimant did not complain of dizziness or vertigo as a result of her December 15, 2010, fall. According to the doctor, claimant only complained of her knees. Dr. Vogt confirmed that

at the January 5 appointment she told claimant to return for a recheck in two weeks, but claimant failed to do so.

At the regular hearing, claimant testified that while in Las Vegas she saw Dr. Maria Regalado on March 23, 2011, for dizziness, among other things. Also while in Las Vegas, claimant was hospitalized in April 2011 for two days at Sunrise Hospital and Medical Center. Claimant indicated she underwent an EKG, MRI, CT scan of the head and a cardiovascular ultrasound. According to claimant, the tests were to check out her heart condition, which she felt was related to her fall at work. She acknowledged making complaints of loss of vision, left arm weakness and abdominal pain. At the regular hearing, claimant testified she returned to Kansas at the end of April 2011.

Claimant, at her deposition, testified she returned to Kansas because in Kansas, she was not charged for her medical care under Medicaid. Claimant indicated that when she returned to Kansas in April 2011, she sought treatment for her dizziness at Shawnee County Health Agency where she saw Traci Harsch, ARNP. According to claimant, she also received treatment for her knees from Ms. Harsch. Ms. Harsch referred claimant to Dr. James Hurtig of the Heart Center, who treated claimant from May through June 2011 for her heart. Because of her dizziness, claimant was referred by Dr. Hurtig to audiologist Dr. Gary McKnight, who began treating claimant in August 2011 and last saw her in March 2014.

Claimant testified that the next time she received medical treatment for either knee was when she saw Dr. Donald Mead on March 20, 2012. Claimant testified Dr. Mead referred her to orthopedist Dr. John H. Gilbert, who first saw claimant on April 6, 2012, and provided treatment, including prescribing physical therapy. Claimant indicated Drs. Mead and Gilbert treated only her right knee. At claimant's deposition, she indicated she last saw Dr. Gilbert on June 15, 2012,[1] and he determined she was at maximum medical improvement. Claimant indicated she was provided permanent restrictions by Dr. Gilbert. Respondent authorized the treatment provided by Drs. Mead and Gilbert.

On April 18, 2012, claimant filed an Application for Hearing alleging head, back and bilateral knee injuries. Claimant testified she personally never paid any medical bills related to her work injuries. She indicated she mailed her physical therapy notes from Dr. Gilbert to respondent.

Nicole E. Jenkins, a claims adjustor for AIG Claims, Inc., testified claimant's file was initially closed by AIG on July 26, 2011. Ms. Jenkins testified that in May 2011, claimant was notified AIG had reviewed her file, she had not been compliant with treatment and if AIG did not hear from claimant, AIG would be reviewing the file for closure. A copy of the notification was not placed in the record.

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[1] At the regular hearing, claimant indicated the date was June 12, 2012.

Ms. Jenkins indicated claimant's file was reopened in February 2012 and she was assigned the claim in May 2012. Ms. Jenkins was not asked why the file was reopened in February 2012. Records from AIG showed claimant incurred medical bills on December 22 and 29, 2010, and January 5, 2011. The last of those medical expenses was paid by AIG on August 3, 2011.

According to AIG's records and Ms. Jenkins' testimony, in 2012, AIG paid authorized medical expenses on April 21, May 7 and 17, June 4, July 13 and October 25. Those payments were for service dates ranging from March 20 through June 29, 2012. In 2013, payments for authorized medical expenses were made from April 15 through September 4 for service dates ranging from March 20, 2012, through July 31, 2013. Ms. Jenkins indicated the last date any medical was paid by the insurance carrier on claimant's claim was September 5, 2013. AIG's records indicate that was for the service dates of July 26, 2013, through August 23, 2013.

The payment records of AIG do not show any payments made to Dr. Hurtig or Dr. McKnight or in connection with Ms. Harsch. Neither Ms. Jenkins nor claimant testified how claimant came to resume authorized medical treatment with Drs. Mead and Gilbert commencing March 20, 2012. Dr. Gilbert testified he saw claimant on the referral of Dr. Mead. Dr. Mead did not testify.

PRINCIPLES OF LAW AND ANALYSIS

K.S.A. 44-557(a) requires that a report of accident must be made to the Director of Workers Compensation within 28 days after the employer had knowledge of the accident. K.S.A. 44-557(c) provides that where no report of accident is filed, the injured worker has one year from the date of the last medical treatment authorized by the employer to file a written claim.

K.S.A. 44-520a(a) states:

> No proceedings for compensation shall be maintainable under the workmen's compensation act unless a written claim for compensation shall be served upon the employer by delivering such written claim to him or his duly authorized agent, or by delivering such written claim to him by registered or certified mail within two hundred (200) days after the date of the accident, or in cases where compensation payments have been suspended within two hundred (200) days after the date of the last payment of compensation; or within one (1) year after the death of the injured employee if death results from the injury within five (5) years after the date of such accident.

At oral argument, claimant asserted respondent may not have filed an Employer's Report of Accident. Claimant's submission letter to the ALJ and brief to the Board did not address this issue. Nor was evidence presented prior to the Award in support of claimant's

assertion. K.S.A. 2010 Supp. 44-555c(a) permits the Board to consider questions of law and fact presented to the ALJ. Therefore, the Board cannot consider this issue.

Claimant's date of accident was December 15, 2010. She received authorized medical treatment on December 22 and 29, 2010, and on January 5, 2011. Claimant next received authorized medical treatment on March 20, 2012. Consequently, there was a gap in payment of authorized medical expenses from August 3, 2011, until April 21, 2012. Respondent last paid an authorized medical expense on September 5, 2013.

Claimant asserts her Application for Hearing, filed on April 18, 2012, constituted timely written claim under K.S.A. 44-520a(a) because it was made prior to September 5, 2013, the last day medical compensation was paid by respondent. Claimant asserts respondent never notified claimant her authorized medical treatment was being withdrawn or terminated. Respondent authorized claimant's medical treatment commencing in March 2012, and paid her last medical expense on September 5, 2013. Therefore, according to claimant, the period claimant had to file a written claim was extended to 200 days from September 5, 2013.

Claimant asserts that if an employer is on notice an injured worker is seeking additional medical treatment on the assumption that the treatment is authorized by the employer, the employer is under a positive duty to disabuse the injured worker of that assumption if the employer intends to rely on the 200-day limit. Claimant relies on *Blake*.[2] Mr. Blake received authorized treatment for his March 27, 1969, work injury from Drs. O'Donnell and Coffey. The insurance carrier paid the medical bills of Drs. O'Donnell and Coffey and weekly compensation to January 1, 1970. Payment of weekly compensation was discontinued after that date for no reason that appeared in the record. In April 1970, Mr. Blake called the insurance carrier and, after talking to someone and complaining, was sent a check from the insurance carrier paying his weekly compensation to April 16, 1970. That was the last weekly compensation paid.

In April 1970, Mr. Blake went to see Dr. O'Donnell, the authorized treating physician, who referred claimant to Dr. Kiene. Dr. Kiene, in turn, referred Mr. Blake to Dr. McFarland, who hospitalized claimant. No bills were sent to Mr. Blake, nor was there ever any notice to him that they would not be paid. Mr. Blake assumed the bills were paid or would be paid by the insurance carrier.

No notice was ever sent by Hutchinson Manufacturing or its insurance carrier to Mr. Blake or Dr. O'Donnell indicating Dr. O'Donnell was no longer authorized. Claimant served written claim upon Hutchinson Manufacturing on November 25, 1970. The Kansas

[2] *Blake v. Hutchinson Manufacturing Co.*, 213 Kan. 511, 516 P.2d 1008 (1973).

Supreme Court, relying on *Johnson*,[3] determined claimant provided timely written claim. The Court stated:

> There was never any notice either to the doctor or to the claimant that the authority of Dr. O'Donnell had been revoked. The inference which claimant was entitled to draw from the action of the carrier in complying with his request in April to make further payment of weekly compensation was that of continuing authority for both treatment and referral.
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> . . .
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> We therefore hold that, in accordance with *Johnson v. Skelly Oil Co.*, supra, where the employer and insurance carrier have once authorized a course of treatment for a workman they cannot effect a "suspension" of such compensation, and start the workman's claim time running, merely by failing to pay the medical bills as they are received. At least where the respondents are on notice that the workman is seeking additional treatment on the assumption that he is still covered they are under a positive duty to disabuse him of that assumption if they intend to rely on the 200 day statute.[4]

In the present claim, claimant was not paid temporary total disability benefits. Claimant did not seek additional medical treatment from Dr. Vogt, who was authorized by respondent. After January 5, 2011, claimant received medical treatment in Las Vegas, but did not seek authorization from respondent for that treatment. The next time claimant received authorized treatment after January 5, 2011, was on March 20, 2012. By then, more than 200 days had passed since claimant last received compensation.

Conversely, respondent argues the 200-day period claimant had to file her written claim expired and a subsequent payment of compensation does not extend the 200-day period. Respondent relies on *Rutledge*.[5] Mr. Rutledge was injured on August 18, 1954. G.S. 1949, 44-520a required written claim for compensation be filed within 120 days after the accident. Sandlin provided authorized medical treatment to Mr. Rutledge on August 13, 1955. Mr. Rutledge served his written claim upon Sandlin on November 17, 1955. The trial court found Mr. Rutledge served the written claim within 120 days after medical and hospital services were furnished by Sandlin. The Kansas Supreme Court reversed, stating:

> . . . we must hold the written claim must be filed within 120 days from the date of the accident irrespective of when the resulting injury is discovered. After the expiration

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[3] *Johnson v. Skelly Oil Co.*, 180 Kan. 275, 303 P.2d 172 (1956).

[4] *Blake*, 213 Kan. at 513-15.

[5] *Rutledge v. Sandlin*, 181 Kan. 369, 310 P.2d 950 (1957).

> of the 120 days any medical treatment or other compensation is ineffective to revive the injured workman's right to file his written claim. It follows the judgment of the trial court must be reversed and compensation denied.[6]

The Kansas Court of Appeals, in *Shields*,[7] recognized an injured worker has some duty to pursue medical treatment for his or her injury. Ms. Shields sustained a work accident on April 17, 1990. Ms. Shields was provided medical treatment on April 18, 1990, and she received physical therapy. During physical therapy, a TENS unit was prescribed. She was provided a TENS unit along with a year's worth of supplies to operate the TENS unit. After receiving one week of physical therapy, Ms. Shields returned to the doctor on May 9, 1990, and was released to full duty work, without restrictions, beginning May 14, 1990. A return appointment was scheduled on May 29, 1990. Ms. Shields never returned for her follow-up appointment. On May 15, 1990, the company supplying the TENS unit sent Ms. Shields a letter asking for its return when she had discontinued its use. The letter also included contact information to order additional supplies. Ms. Shields testified that to her knowledge, she was to use the unit until the pain went away.

Between May 9, 1990, and January 29, 1991, Ms. Shields sought no medical treatment. She filed a written claim for compensation on February 6, 1991. The insurance carrier authorized medical treatment in conjunction with Ms. Shields' separate claim for compensation in Missouri between February 20, 1991, and May 8, 1991. In June 1991, Ms. Shields requested additional TENS unit supplies, but her request was denied.

The length of time between Ms. Shields' authorized medical treatment on May 9, 1990, and the date of her claim for compensation was 273 days. Ms. Shields maintained her continued use of the TENS unit until June 1991 constituted "payment of compensation" within the meaning of the Workers Compensation Act, and, therefore, the time for filing her claim did not begin to run until that time. The ALJ found Ms. Shields provided timely written claim because she was still receiving authorized medical treatment when she filed her written claim. The Board reversed, finding that Ms. Shields' unsupervised use of the TENS unit did not constitute ongoing medical treatment for purposes of tolling the 200-day limitation period of K.S.A. 44-520a(a). The Kansas Court of Appeals affirmed the Board and found Ms. Shields did not provide timely written claim. The Court stated:

> Shields has experienced no reduction in the level of pain she associates with her injuries. It is reasonable to conclude that a worker in Shields' condition would seek out her treating physician for continued treatment, rather than suffer for 8 months before seeking additional medical care from an alternative source. Additionally, Shields' failure to return for the May 29, 1990, follow-up appointment could be viewed as a unilateral decision by Shields to abandon her medical

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[6] *Id.* at 372.

[7] *Shields v. J. E. Dunn Constr. Co.,* 24 Kan. App. 2d 382, 946 P.2d 94 (1997).

> treatment. Had she returned as scheduled, her injuries might well have been addressed through an authorized course of treatment. Although her continued use of the TENS unit is uncontroverted, the unsupervised use of the unit, in conjunction with her testimony that she continued to experience debilitating pain from her injuries and her conflicting testimony regarding her ability to return for treatment, leads us to the conclusion that Shields was not operating under a reasonable assumption that her medical treatment was ongoing. She was released back to work with no restrictions. As far as her employer or its insured knew, this was the last time Shields received any medical treatment. It would be difficult to say that her employer was "on notice" of Shields' ongoing medical treatment, notwithstanding the reference made to the TENS unit in her medical reports.[8]

The Board finds claimant failed to provide timely written claim. K.S.A. 44-520a(a) requires an injured worker to file a written claim for compensation within 200 days after the date of his or her accident, or in cases where compensation has been suspended, within 200 days after the date of the last payment of compensation. The 200-day period to file a written claim commenced on December 15, 2010, claimant's date of accident. *Rutledge* recognizes the period to file timely written claim commences on the date of an injured worker's accident and any medical treatment or other compensation is ineffective to revive the injured worker's right to file his or her written claim.

Moreover, *Shields* stands for the proposition that an injured worker has some duty to seek authorized medical treatment. Respondent provided claimant medical treatment in December 2010 and January 2011. On January 5, 2011, Dr. Vogt told claimant to return in two weeks, but claimant did not do so. Claimant presented insufficient evidence that she sought authorized medical treatment from January 5, 2011, until she saw Dr. Mead on March 20, 2012, a period of approximately 14 months. That is similar to *Shields*, where Ms. Shields failed to attend a follow-up appointment and did not seek additional medical treatment for approximately eight months.

CONCLUSION

Claimant did not provide timely written claim as required by K.S.A. 44-520a(a).

As required by the Workers Compensation Act, all five members of the Board have considered the evidence and issues presented in this appeal.[9] Accordingly, the findings and conclusions set forth above reflect the majority's decision and the signatures below attest that this decision is that of the majority.

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[8] *Id.* at 386.

[9] K.S.A. 2013 Supp. 44-555c(j).

AWARD

WHEREFORE, the Board affirms the September 8, 2014, Award entered by SALJ Shelor.

IT IS SO ORDERED.

Dated this ____ day of March, 2015.

BOARD MEMBER

BOARD MEMBER

BOARD MEMBER

c: Jeff K. Cooper, Attorney for Claimant
jeff@jkcooperlaw.com; toni@jkcooperlaw.com

Matthew S. Crowley, Attorney for Respondent and its Insurance Carrier
Matt@crowley-law.com; courtney@crowley-law.com

Honorable Jerry Shelor, Special Administrative Law Judge

Rebecca Sanders, Administrative Law Judge